UNITED STATES DISTRICT COURT

DISTRICT OF MASSACHUSETTS

NO. 01CV12257-PBS

In re: PHARMACEUTICAL)
INDUSTRY AVERAGE WHOLESALE)
PRICE LITIGATION)
)
THIS DOCUMENT RELATES TO:)
ALL ACTIONS)

HIGHLY CONFIDENTIAL

VIDEOTAPED DEPOSITION OF SHEILA R. CIZAUSKAS

800 BOYLSTON STREET

BOSTON, MASSACHUSETTS

FRIDAY, 10 MARCH, 2006

9:38 AM

VIDEOTAPED DEPOSITION of SHEILA R. CIZAUSKAS, called as a witness by and on behalf of Johnson & Johnson, pursuant to the applicable provisions of the Federal Rules of Civil Procedure, before P. Jodi Ohnemus, Notary Public, Certified Shorthand Reporter, Certified Realtime Reporter, and Registered Merit Reporter, within and for the Commonwealth of Massachusetts, at the offices of Robins, Kaplan, Miller & Ciresi, L.L.P., 800 Boylston Street, Boston, Massachusetts, on Friday, 10 March, 2006, commencing at 9:38 a.m.

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ALSO PRESENT:

George Libares, Videographer

VIDEO OPERATOR: We are now recording and on the record. My name is George Libares. I'm a certified legal video specialist for Henderson Legal Service. Our business address is 1120 G Street Northwest, Suite 1010, Washington, DC 20005.

Today's date is March 10th, 2006, and the time is 9:38 a.m. This is the deposition of Sheila Cizauskas, in re: The pharmaceutical industry average wholesale price litigation. This deposition is being taken at 800 Boylston Street, Boston, Massachusetts. The court reporter is Jodi Ohnemus. Counsel will now state their appearances, and the court reporter will administer the oath.

MR. MANGI: Adeel Mangi, Patterson, Belknap, Webb & Tyler, for Johnson & Johnson.

MR. MIZELL: Nicholas Mizell, Shook, Hardy & Bacon, for Aventis Pharmaceuticals.

MR. COCO: Steven Coco from Robins, Kaplan, Miller & Ciresi, for Blue Cross Blue Shield of Massachusetts.

MR. NOTARGIACOMO: Ed Notargiacomo from Hagens, Berman, Sobol & Shapiro, for class Plaintiffs.

MR. SKWARA: Steve Skwara for Blue Cross Blue Shield of Massachusetts.

MR. MANGI: Good morning, Ms. Cizauskas.

MS. CIZAUSKAS: Good morning.

SHEILA R. CIZAUSKAS,
having first been duly sworn,
testified as follows to
direct interrogatories.

MR. COCO: Before you start, one of the things that we forgot to do on the record yesterday was to designate yesterday's transcript as highly confidential. I had a conversation with the court reporter after you had left yesterday, asking her to put that designation on that transcript. I just wanted to memorialize that for the record.

MR. MANGI: I sent Ed an e-mail on the topic. That's fine.

MR. COCO: Okay. And I believe, based on what I expect the topics to be for this transcript, that we will also be designating this as highly confidential.

MR. MANGI: No objection.

BY MR. MANGI:

Q. Now, sorry for so much formality so early in the day.

Ms. Cizauskas, could you please tell me your current job title.

A. Senior director of provider contracting, Blue Cross & Blue Shield of Massachusetts.

Q. How long have you held that title?

A. Since May of 2003.

Q. And how long have you been at Blue Cross Blue Shield of Massachusetts?

A. Since May of 2003.

Q. So, you've held one title throughout your time at the company?

A. Yes.

Q. Going back a bit further in time, could you describe for me, please, your educational background after high school.

A. Graduated from high school and went to nursing school for a Licensed Practical Nurse degree and then many years later, received my

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bachelor of science degree and then a master of business administration degree.
Q. Now, when you went to nursing school, did you complete the course of study you had started?
A. Yes.
Q. And what qualification did you receive?
A. Licensed Practical Nurse.
Q. When did you receive that qualification?
A. 1970.
Q. After qualifying as a nurse, did you work as a nurse?
A. Yes.
Q. Okay. Where did you work?
A. I worked at a nursing home in Waterbury, Connecticut; and then after I was married, I worked for a -- an oral surgeon in East Hartford, Connecticut, and then another oral surgeon in West Hartford, Connecticut; and I worked for a hematologist and cardiologist in Hartford, Connecticut.
Q. Now, in each of those positions, were you working as a nurse?

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A. Yes.
Q. And what was the total time period for which you were working as a nurse?
A. Five years.
Q. 1970 to 1975?
A. Well, actually, 1969 -- so, I sort of -- before I received my -- my license, and then to 1974 when my first child was born.
Q. Now, in any of those positions when you were working as a nurse, did you have any responsibilities related to the manner in which the nursing home or the doctors for whom you were working acquired drugs?
A. No.
Q. Were your responsibilities entirely clinical?
A. Some administrative.
Q. What sort of administrative work did you do?
A. Making appointments, calling patients to remind them of appointments, things like that.
Q. Did you have any responsibilities in

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relation to ordering of supplies, financial responsibilities around accounting, things like that?
A. No.
Q. In 1974, I believe you mentioned you had a child?
A. Yes.
Q. Okay. Did you stop working then for a period of time?
A. Yes, I did.
Q. How long did you -- how long before you next started working again?
A. I believe that child was in high school, and I worked part-time job at a technical high school running a banking program, and ran the -- ran a bank in the high school for the Hudson National Bank.
Q. Did you get your bachelor's degree before or after you started that high school --
A. After.
Q. So, let's go in chronological order then.
A. Okay.

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Q. So, you started working at the high school sometime around -- in the mid '80s?
A. Yes.
Q. Okay. Do you know when -- what year that was?
A. I can't remember exactly what year. It was -- it was mid '80s, though. And then I left that job in '89 to attend undergrad school full time.
Q. Where did you attend undergraduate school?
A. Framingham State College.
Q. Was that a four-year program?
A. It was, and I completed it in three years.
Q. And that was a BSC degree, right?
A. Yes.
Q. What were your areas of study?
A. Business, economics, finance, my major was in business administration, some -- a minor in psychology.
Q. So, you completed that degree in --
A. '91.
Q. '91. What did you do after that?

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A. Then I went to Clark University Graduate School of Management for an MBA.
Q. You went directly from your bachelor's degree to the MBA program?
A. Yes.
Q. Was that a two-year MBA?
A. Yes.
Q. Did you complete that in '93?
A. Completed it in the spring of '93.
Q. What did you do after receiving your master's degree?
A. Well, the -- the summer before I graduated I did an internship with CIGNA, and then when I graduated, CIGNA hired me as a consultant for some project work, and then I went to work for Private Health Care Systems full time.
Q. Well, let's stick with CIGNA for a moment.
A. Uh-huh.
Q. They hired you in '93. How long did you remain at CIGNA?
A. About a year.
Q. And were you working as a consultant for

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that entire period?
A. Yes.
Q. Did you have any particular title while you were at CIGNA?
A. No.
Q. What projects were you tasked with handling for CIGNA?
A. Originally, I was -- I developed an early discharge program for OB patients. It was a voluntary program that gave incentives to mothers if they went home early. At that point in time it was a longer length of stay that was customary, and there was some desire to provide incentives for a shorter length of stay.
And so, I developed the program and visited the OB offices to introduce it to the -- to the physicians.
Q. All right.
A. And then the next project I had was to develop a network in Maine for a particular account up there -- Pratt & Whitney -- and to develop a physician and hospital network for CIGNA.

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Q. Any other projects?
A. There was a very short period where I was tasked with exploring a -- a worker's comp network in Massachusetts, but that was abandoned quickly.
Q. Anything else?
A. That's it.
Q. Now, the second project you mentioned, developing the physician and hospital network in Maine, did CIGNA not have a network in Maine at that time?
A. That's right. They had -- it was either very limited or not at all. So, it was my task to -- to bring that online.
Q. And was the impetus for developing that network the fact that CIGNA had a new client --
A. Yes.
Q. -- with a presence in that area?
A. Yes.
Q. And that was Pratt & Whitney?
A. Right. Maybe they were called United Technologies at that time. I'm not sure.
Q. How did you go about developing a network

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in Maine?
A. I received a list of physicians and a map and visited offices. It was really, you know, a lot of fieldwork and knocking on doors and meeting with physicians and their office staff, describing the managed care product, and following up to get signatures on the -- on the contracts.
Q. In that time period, '93, were the physicians in Maine generally familiar with managed care?
A. They were familiar with it. They were not organized at the time in large groups, so it was all individual discussions for the most part.
Q. Were there other health insurers already active in Maine with their own provider network?
A. Yes.
Q. What other insurers had a presence?
A. I can't really -- I can't really remember. No, I can't remember.
Q. Did the physicians you visited already have contracts with other health insurers?
A. Some did. Some did not.

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Q. Were the majority of them already contracted or not contracted?
A. I would say, to the best of my recollection, not. It was a very new marketplace for managed care.
Q. Did there -- did whether or not they already had other contracts with other insurers affect their willingness or readiness to contract with CIGNA?
A. Not really.
Q. What were some of the issues that physicians were interested in discussing with you prior to making a decision about whether or not to join the CIGNA network?
A. How much membership CIGNA was representing, and whether or not their patients would be -- their current patients who were part of the United Technologies or Pratt & Whitney account, and how much money was currently running through those patients, and what the fee schedule was.
Q. What do you mean when you say how much money is currently running through those patients?

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Were you referring to the CIGNA -- to the --
A. No, the United technologies. So, I would have a list of patients that were using the particular doctor I was seeing and what their -- you know, what their utilization was or how often they visited that doctor. And so, it was -- the discussion was, you know, that these patients would need to use a CIGNA doctor, and that, if they were not part of the network, then the patient may need to change doctors. And so, there was value to the doctor in participating in the network.
Q. And when they wanted to know how many members CIGNA had, were they inquiring about the plan generally or about in their area?
A. In their area.
Q. So, they were interested in knowing how many additional patients they might expect to see if they joined?
A. Yes.
Q. Now, you also mentioned they were interested in fee schedules. Did they want to know how much they'd be paid for services rendered to

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patients?
A. Yes.
Q. Okay. How was the CIGNA -- well, withdraw that. At that point for Maine, did CIGNA have one fee schedule or more than one fee schedule?
A. One fee schedule.
Q. Did that fee schedule encompass both services and drugs administered in office?
A. I don't remember the specifics of the fee schedule. Mostly I was showing a market basket of fees that were relevant to that particular doctor.
Q. Now, the network that you were trying to set up there in Maine, was this a primary care network, or did it include different specialties?
A. It included different specialties and primary care.
Q. Was it intend to be -- intended to be a comprehensive network? In other words, doctors from every major specialty?
A. Yes.
Q. Do you know what methodology CIGNA was using at that time to reimburse physicians for the

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drugs that they administered in their offices?
A. No.
Q. Do you recall any discussion with physicians in relation to what amount they would be reimbursed for drugs administered in office?
A. No.
Q. So, when you refer to discussions about fee schedules, were the discussions that you recall only about services?
A. Mostly about office visits and services that would be unique to the specialty. So, cardiac services for the cardiologist, and so forth.
Q. How were -- how were the amounts that CIGNA was paying for services determined at that time?
A. I don't know.
Q. So, the sample -- the market basket fee schedules that you were showing --
A. Uh-huh.
Q. -- providers, were those expressed just as flat dollar sums?
A. Yes.

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Q. And so, there would be a particular procedure code, its description, and then a dollar amount --
A. Correct.
Q. -- associated with it.
A. Correct.
Q. Was the effort to set up a network in Maine successful?
A. Yes.
Q. How large was the Maine network that you set up?
A. It covered southern Maine from Portland south. So, it -- it didn't go any further north than that. And I can't remember the number of doctors. I know that the major hospitals were included, and the network of doctors was adequate to provide access to the membership.
Q. Did you have any responsibilities in relation to the Maine network after the initial push towards contracting?
A. I was responsible for making sure that the information about the doctor was entered into the

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system and that the credentialing of the physicians occurred, and I followed through on, you know, making sure all of the elements of credentialing were collected.
Q. Were the terms that CIGNA offered to physicians in Maine uniform, or was there individualized variation?
A. They were uniform for the physicians, and there were individual variations at the hospitals.
Q. When you say, "uniform for physicians," was that uniform across specialties?
A. There was a fee schedule, and there was no deviation on the fee schedule. So, it was a comprehensive fee schedule.
Q. So, for physicians, that one fee schedule applied equally to a rheumatoid arthritis -- I forgot what they're called -- it applied equally to a rheumatologist as it did to an oncologist?
A. Yes.
Q. And that same fee schedule applied equally to Oncologist A as it did to Oncologist B?
A. Yes.

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Q. Okay. Now, why was there a variation in the terms offered to hospitals but not physicians?
A. I wasn't directly involved with most of the hospital negotiations, but it was generally a negotiation on rates at the hospitals.
Q. Why was there a need to negotiate rates with hospitals but not with physicians?
A. I can't speak to the CIGNA days, but just in general, it usually depends on the underlying cost structure of a hospital.
Q. What do you mean by that?
A. A tertiary hospital may have a higher cost structure than a community hospital.
Q. So, if a hospital has a different set of costs versus another hospital, they would expect to receive different reimbursement that takes account of the fact that they have --
A. Right.
Q. -- different costs. Is that principle generally applicable in the marketplace? In other words, when you're contracting with an entity for reimbursement, if their costs are different, that

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may be a basis for them seeking different amounts of reimbursement.
MR. COCO: Objection. You may answer.
A. It's one of many components in a negotiation.
Q. Now, after you completed your stint at CIGNA in 1994, where did you go next?
A. Private Health Care Systems.
Q. What was Private Health Care Systems?
A. It's a national PPO organization that's -- at that time was owned by a consortium of individual insurance companies, and it provided the network and the utilization review services to those insurance companies.
Q. How long did you work for Private Health Care Systems?
A. Three years.
Q. So, approximately '94 to '97?
A. Yes.
Q. Now, can you help me understand what a national PPO organization is? What is its function in the marketplace of managed care?

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A. It develops networks across the country. Private Health Care Systems at that time had four regional -- regions and many regional offices throughout the country and had a staff in each regional office that was responsible for developing a network and negotiating hospital rates and physician fee schedules and offering it to the owner insurance companies for their products.
Q. Now, are there other entities in the market that develop -- similarly develop networks which are not owned by insurance companies?
A. Say that again, please.
Q. Sure. Are there other entities in the market that develop physician networks --
A. Uh-huh.
Q. -- which are independent commercial entities not owned by health insurers?
MR. COCO: Objection.
A. I'm -- I'm not sure.
Q. Okay. In this instance, the -- did -- which insurers owned Private Health Care Systems?
A. I'm not going to remember all of them, but

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Great -- Great West, Guardian -- oh, let's see. I -- I can't remember some of the smaller ones, but there were maybe nine or ten. Great West stands out because it -- the representative from Great West was chairman of the board. Guardian I remember because I -- I visited them. I can't remember offhand. I could probably look it up for you.
Q. Why -- why did these health plans band together to set up Private Health Care Systems rather than just setting up their own networks?
A. I think it was economy of scales.
Q. What do you mean by that?
A. Well, I mean that they -- probably wouldn't be economically feasible for each of them to duplicate the network, and they had national business and needed a national network.
Q. Would the difficulties in setting up their own network that you're referring to be purely administrative, or are you thinking of something else as well?
A. I'm thinking that they'd each have to have

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a staff to -- to develop and manage the network, and it would be a duplication of efforts; that Private Health Care Systems provided the same network to everyone.
Q. Would banding together in this manner to negotiate contracts with providers give these insurers greater leverage in the marketplace than they may have had if they went in alone?
MR. COCO: Objection.
A. Yes.
Q. So, that greater leverage would enable them to negotiate better reimbursement terms and save money in the amounts they were paying in reimbursement.
MR. COCO: Objection.
A. I'm not sure that it -- I'm not sure that that was the case, except that it provided more membership in a particular market.
Q. Okay. Well, as a general matter, when health insurers and providers come together to negotiate the terms of reimbursement, the health insurers are trying to pay the lowest amount they

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can, while still paying enough to get a stable and adequate network, right?
MR. COCO: Objection.
A. Yes.
Q. Okay. Whereas, from the provider's side, the provider, among other things, is looking to maximize the amount of reimbursement that they can get from the health insurance side, right?
MR. COCO: Objection.
A. I can't speak for the provider. I think there are a number of values that an insurer will bring to the provider, that being one of them.
Q. So, that will be one of the -- one of other -- one of many goals that a provider may have when entering into a negotiation with an insurer.
MR. COCO: Objection.
A. Yes.
Q. Now, when the parties would come together in that negotiation dynamic with these different and competing goals, to some extent, would the fact that Private Health Care Systems was a -- represented a consortium of nine or ten insurers --

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give them greater bargaining power at the table than, say, Great West may have had on its own?
MR. COCO: Objection.
A. Yes.
Q. What was your role at Private Health Care Systems?
A. Originally, my role was a managed care coordinator, and I was responsible for building a network in Connecticut.
Q. How long did you hold the title of managed care coordinator?
A. Less than a year, and then I was recruited to work in the finance area, and my title was senior analyst.
Q. How long did you hold that position?
A. Less than a year. And then I was asked to take a position in Manhattan to manage the New York, northern New Jersey, and Connecticut markets and then --
Q. What was your title in that role?
A. And then I was director of managed care.
Q. When you were in Manhattan as manager of

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those networks, what was your --
A. Director of managed care.
Q. Was there more than one director of managed care?
A. There was a director of managed care for each region, and so, that was the region that I managed.
Q. Now, the first role you had as managed care coordinator, was this a similar job to what you had done for CIGNA in Maine?
A. Yes.
Q. Did you approach the task in the same way?
A. Yes.
Q. So, you went out and met with physicians and hospitals to try and build up a network?
A. Mostly physicians, and yes.
Q. Okay. Now, turning back to the global structure of Private Health Care Systems, Private Health Care Systems itself entered into contracts with providers, right?
A. At that time there was a single contract, with individual signatures from each of the

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entities that owned the organization.
Q. I see. So, there was one master contract, but Private Health Care Systems was just the -- the intermediary that worked to set it up. The actual contract was between each insurer and the physician practice?
A. Correct.
Q. Okay. Did -- were there ever instances where the various insurers that made up Private Health Care Systems negotiated different deals with the same doctor?
A. I don't think so.
Q. Were there ever instances where not all of the health insurers that made up Private Health Care Systems signed or joined the contract with a particular provider?
A. Not that I can remember.
Q. Okay. So, as far as you know, it was always uniform in the sense that all of the insurers making up Private Health Care Systems would be signatories to every contract with every physician?

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A. As far as I can remember, yes.
Q. Were the terms of the contracts determined by people at the individual insurance companies working together, or by a full-time staff at Private Health Care Systems?
A. At Private Health Care Systems.
Q. And did Private Health Care Systems' contracting staff coordinator liaise with contracting staff at the constituent insurance companies?
A. No.
Q. So, the insurance companies delegated the contracting task entirely to the staff at Private Health Care Systems?
A. Private Health Care staff did the contracting. I don't know about the word "delegation," if that's a formal word, but you know, yes.
Q. It wasn't intended to be.
A. Okay.
Q. Let me rephrase it so there's no confusion. The private insurance companies that

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made up Private Health Care Systems allowed the staff at Private Health Care Systems to make their own decisions as to what terms should be included in the contracts that they would negotiate with providers.
A. Yes.
Q. Okay. Now, in this time period when you were a managed care coordinator responsible for building the network in Connecticut, was there one fee schedule applicable to Connecticut or more than one?
A. I think there was two.
Q. What was the variation between the two contracts?
A. One was the Fairfield County, and the other was the rest of Connecticut -- best of my memory.
Q. Why was there a distinction between Fairfield versus the rest of Connecticut?
A. I don't know.
Q. Do you know whether one fee schedule contained higher rates than the other?

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A. Yes.
Q. Which one was higher?
A. Fairfield County.
Q. Is Fairfield County a -- does that include the big cities in Connecticut, or is that a largely rural area?
A. It's a suburb of New York, so it's Greenwich and communities close to New York.
Q. Was there a greater concentration of physicians in the Fairfield area or in the rest of Connecticut area?
A. I don't know.
Q. In Fairfield did the one fee schedule govern all different specialties?
A. Yes.
Q. And similarly, did the rest of Connecticut -- in the rest of Connecticut, did the one fee schedule cover all specialties?
A. Yes.
Q. Was there any individualized negotiation with provider groups in either area?
A. Not on the fee schedule, but the -- there

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were meetings and -- and attempt to bring individual provider groups in.
Q. Okay. Were -- was there a negotiation of terms of the contracts other than the fee schedules?
A. No.
Q. Okay. So, there were meetings -- when you say there were meetings, were those designed to try and explain the contract and the terms to the providers?
A. Yes.
Q. Okay.
A. And we're talking about physicians.
Q. Yeah, physicians.
A. Yes.
Q. But there would be no changes from the form contract that was offered.
A. No.
Q. Now, both at CIGNA and at Private Health Care Systems, do you have any idea how the amounts that were set in the fee schedules were determined?
MR. COCO: Objection.

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A. At CIGNA, I don't know. At Private Health Care Systems, there was a point in time, and I don't remember when, when the Medicare methodology -- RBRVS -- was adopted, and I don't know when that was.
Q. Did Private Health Care Systems pay at the same rate as Medicare, or did they use RBRVS methodology but then apply a multiplier or in any other way change the amounts specified?
A. They did -- they used the Medicare methodology and had a different conversion factor that would change the amount.
Q. Were the amounts that Private Health Care Systems was reimbursing for services at greater than or lesser than the amounts Medicare was reimbursing for the same services?
A. Greater than.
Q. Why was Private Health Care Systems paying amounts greater than Medicare?
A. It was necessary to have contracts with the physicians to pay at a level higher than Medicare.

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Q. It's a function of market demand and supply?
A. Yeah.
Q. In other words, the market would not accept Medicare rates, and if Private Health Care Systems offered those rates, it wouldn't be able to sign up an adequate --
A. Correct.
MR. COCO: Objection.
Q. Now, what about in relation to drugs administered in physicians' offices, what methodology was Private Health Care Systems using as regards that reimbursement?
A. Don't know.
Q. Do you know whether or not the fee schedules that you were negotiating with these providers had sections dealing with drugs administered in office?
A. I don't know.
Q. Were all of the contracts that you negotiated on behalf of Private Health Care Systems fee-for-service contracts?

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A. Yes.
Q. There were no other methodologies used?
A. On the physician side, I believe they were all fee-for-service contracts.
Q. Then in the '95, '96 period you were a senior analyst in the finance department.
A. Yes.
Q. What were your responsibilities in that role?
A. I did some reporting to accounts and did reporting on their utilization trends from one year to the next.
Q. Were you analyzing the utilization trends of specific physician offices or on a global level?
A. It was a -- more of a regional level --
Q. Okay.
A. -- or an account-specific level.
Q. Did your analysis focus on services rendered by those -- by physicians in those regions, or did you also look at -- well, withdraw that. Did -- were you focused on services?
A. High level. Inpatient, physician

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services, but high level.
Q. When you say, "inpatient physician services --"
A. Inpatient or physician service, two different --
Q. I see. Did you perform any analysis relating to drug usage or drug costs?
A. I don't remember do -- having any analysis in that category.
Q. Then in '96, '97 you became director of managed care, right?
A. Yes.
Q. What were your responsibilities as a director of managed care?
A. I managed the Manhattan office, and it was intended to be a very short assignment. The -- my predecessor had been let go unexpectedly, and I was asked to fill in temporarily until they found a permanent replacement, but it ended up lasting over a year, and -- until they moved the office to New Jersey. And my responsibility was to manage and enhance and develop the northern New Jersey

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network, the New York State, Manhattan network, and Connecticut.
Q. The managed care in your title, director of managed care, was that a reference to the fact that you were an entity contracting with providers?
A. I'm not sure what the reference to "managed care" was, but that's what I did. I -- I was on the provider side -- on the network side.
Q. The reason I'm -- I asked for clarification is, generally people who have had that title are responsible for dealing with managed care. In other words, dealing with health insurers. But that wasn't the case here. Do I understand correctly?
A. My -- my responsibilities here really were managing the provider networks.
Q. How was your -- how were your responsibilities in this position different from what you had done as a managed care coordinator in Connecticut?
A. I was managing a staff of managed care coordinators; and then there was another level --

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and I can't remember the title -- that handled a higher level of negotiations, and that staff was located in both New York and Waltham, Massachusetts.

Q. Now, by this time, '96, '97, was Private Health Care Systems in the New York, New Jersey, Connecticut market still using an RBRVS methodology in reimbursing physicians for services?

A. Yes.

Q. And were they still applying a multiplier such that they paid an amount higher than Medicare?

A. Yes.

Q. And by this time had you gained an understanding of how Private Health Care Systems was reimbursing physicians for drugs administered in office?

A. No. It was not in my consciousness at the time.

Q. Okay. In 199 -- by the way, sticking with that period, was there -- were the terms of the contracts that were offered still take it or leave it, or was there individualized negotiation?

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MR. COCO: Objection.

A. The physician fee schedules were established by region. But within the region, they were uniform.

Q. So, there was variation by region?

A. Yes.

Q. By this point, had you gained an understanding as to why there was variation by region?

A. Again, I believe it was market dynamics in the region.

Q. And what do you mean by "market dynamics"?

A. What was necessary to obtain a viable network.

Q. In other words, the physicians in some areas expected a higher rate of reimbursement than others.

MR. COCO: Objection.

A. I'm not sure if it -- it basically was, you know, what the organization -- and this was done in a unit outside of my responsibility -- determined was the appropriate level of

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reimbursement in that area.

Q. Well, when you say, "market power," do you mean that in certain areas, in order to get and attract a stable and adequate network, it was necessary to offer a higher rate of reimbursement than it was in others?

A. Yes.

Q. In 1997, did you change jobs?

A. Yes.

Q. Okay. Where did you go in 1997?

A. Harvard Pilgrim Health Care.

Q. How long were you at Harvard Pilgrim?

A. Until April of 19 -- 2003.

Q. And that's when you came to BCBS of Massachusetts.

A. Correct.

Q. Okay. During your six-odd years at Harvard Pilgrim, how many different job titles did you hold?

A. Trying to think. I can't remember if it was two or three. I think it was two.

Q. Okay. What was the first job title that

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you held?

A. Manager of the northern region.

Q. How long was that your title?

A. Couple of years.

Q. And what were you managing as manager of the northern region?

A. I was managing the region north of Boston, Massachusetts, both provider relations and contracting, and managed the staff that covered those two areas.

Q. And what was your second title at Harvard Pilgrim?

A. Director of contracting.

Q. How long did you hold that position?

A. Three or four years.

Q. So, that was from 1999 till you left the company?

A. Yes.

Q. What entities were you responsible for contracting with as director of contracting?

A. Hospitals and large -- risk units they were called, physician risk units.

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Q. Let's talk about the first role you held as -- as manager of the -- of the northern region. Were you responsible for managing networks that had already been set up, or were you creating new networks?
A. I was managing networks that had already been established.
Q. What methodology was Harvard Pilgrim using at this time to reimburse physicians for services that they rendered?
A. Fee schedules and risk -- risk arrangements.
Q. Okay. Now, by "risk arrangements," are you referring to contracts whereby the providers held the risk?
A. There was shared risk between the provider and the health plan.
Q. What structure did the risk arrangements that Harvard Pilgrim was utilizing take?
A. There were a couple of methodologies. One was a budgeted capitation, it was called. So, the entity received a budget -- they were paid fee for

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service during the year, and then, at the end of the term, there was a settlement calculation based on the budget that had been established.
And there was a capitation model where the entity received a fixed amount to provide services to a -- a group of patients.
Q. Okay. Were there any withhold arrangements?
A. Yes.
Q. Any other types of risk arrangements?
A. No.
Q. Okay. So, there was budget capitation, there was capitation models, and there was -- and there were withholds.
A. The withhold and the budgeted capitation were the same method -- methodology.
Q. And the fee schedule reimbursement, that was fee-for-service reimbursement?
A. Yes.
Q. At this point, what proportion of Harvard Pilgrim's physician contracts were fee schedule based, fee-for-service based, as opposed to risk

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based?
MR. COCO: Objection.
A. I couldn't give you a number, but the majority of the arrangements were risk.
Q. When -- what were the factors that determined whether Harvard Pilgrim entered into a fee schedule or fee-for-service arrangement versus a risk-based arrangement with any given physician practice?
MR. COCO: Objection.
A. The risk arrangement was generally offered to groups of physicians that had an infrastructure -- centralized infrastructure -- and a membership that would be suitable for sharing risk level of membership -- a level of membership that was suitable for sharing risk.
Q. By "level of membership," do you mean that a certain minimum number of members were necessary before --
A. Yes.
Q. -- risk sharing became viable?
A. Yes.

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Q. Now, on the fee schedule, fee-for-service side of Harvard Pilgrim's contracting at this time, what was the methodology used to determine the amount in the fee schedules?
A. It was an RBRVS -- well, let me correct that. It had ultimately -- conveniently gone to RBRVS, but originally, at this time, it was a homegrown fee schedule, Harvard Pilgrim-developed fee schedule.
Q. When did Harvard Pilgrim transition from its homegrown fee schedule to RBRVS fee schedules?
A. I can't -- I don't know the exact time frame, but I would say it's towards the late '90s.
Q. Okay. It was during your tenure?
A. Yes.
Q. The homegrown schedule that was used earlier, do you know how that was developed?
A. No.
Q. Do you know whether or not it was related to physician' bill charges in any way?
A. I don't know.
Q. When the RBRVS methodology was adopted,

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were you involved in that transition?
A. Yes.
Q. What were your responsibilities in relation to that transition?
A. Mostly just understanding what RBRVS was, learning more about how it -- what it was and the relativities between services.
Q. And by this time you were already familiar with RBRVS because of your experience with Private Health Care Systems, right?
A. Yes.
Q. So, were you providing advice to others in the group based on your experience with RBRVS?
A. Yes.
Q. Did Harvard Pilgrim move to an RBRVS methodology where they reimbursed at the same rate as Medicare, or did they adopt a multiplier?
A. I -- I wouldn't call it a multiplier. When you say, "multiplier," it's a conversion factor that's applied to the -- to the weights.
Q. Can you help me understand what the difference is between a multiplier versus a

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conversion factor.
A. In my mind -- and this may not be the -- you know, the -- anyone else's -- but a conversion factor is the number that's applied to the weights, and it establishes a fee schedule, and then, you know, if -- if there's a multiplier applied to that, on top of that. So, it would be, across the board, a multiplier. Within the fee schedule there may be different conversion factors or one conversion factor.
Q. Okay. So, Harvard Pilgrim applied -- did it apply one conversion factor to the fee -- Medicare fee schedule or were they different?
A. They were different. There were -- I can't remember how many, but there were a number of multiple -- conversion factors.
Q. As a general matter, though, across the board, was Harvard Pilgrim paying more than Medicare in relation to services?
A. Yes.
Q. And similar to Private Health Care Systems, was that because the market demanded

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higher rates than what Medicare was paying for services?
MR. COCO: Objection.
A. Yes.
Q. Now, were you personally involved in setting conversion factors?
A. No.
Q. But do you know why different conversion factors were applied to different sections of the fee schedule?
A. One of the elements was the -- in the transition from the homegrown fee schedule to the RBRVS fee schedule, the organization looked at how that would impact individual specialties, and if an individual specialty was impacted greater than some threshold, then the conversion factor was set at a level that would minimize that impact.
Q. What sort of impact are you -- are you talking about there? When you say, "impact," what do you mean?
A. Moving from the homegrown fee schedule to the RBRVS fee schedule, if a specialty would have a

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large reduction in their reimbursement.
Q. Was the goal in that transition to keep the amounts of reimbursement in dollar terms stable, but -- while shifting the underlying methodology?
MR. COCO: Objection.
A. Could you repeat that.
Q. Sure. I understand that Harvard Pilgrim was moving from a homegrown fee schedule to an RBRVS methodology.
A. Uh-huh.
Q. Right?
A. Yes.
Q. My question is, was -- in applying conversion factors, was Harvard Pilgrim trying to ensure that the amount it reimbursed to different specialties in dollar terms remained about the same as that which they had been reimbursing using the homegrown fee schedules?
MR. COCO: Objection.
A. They were -- there were two pieces to that: One was the aggregate payments that Harvard

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Pilgrim was making to physicians and managing that to a certain level; and then, within that, managing the impact of any particular specialty so that it wouldn't be a hardship for that specialty, but it didn't mean that the payments would be equal to the previous methodology.
Q. Was the goal to keep them relatively close to each other?
MR. COCO: Objection.
A. No. It was to not have an unmanageable impact, so --
Q. Yeah. What I'm trying to understand is, what would -- what would qualify as an unmanageable impact? In other words, what would be an acceptable impact?
A. Uh-huh.
Q. And what would be an unacceptable impact necessitating the use of a conversion factor?
MR. COCO: Objection.
A. There was a threshold established -- I don't remember what it was -- and that was determined to be the acceptable impact, and if it

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exceeded that, then the conversion factor was manipulated.
Q. Now I follow you. Was it a percentage threshold?
A. Yes.
Q. Okay. And was it a -- a -- was the percentage at the aggregate level?
A. It was a -- it was looking at a specialty category.
Q. Okay. So, let's take oncologists, for example. If oncologists' income would fall by an amount greater than a certain predetermined percentage as a result of the transition, that would qualify as an unacceptable impact and a conversion factor would then be applied.
MR. COCO: Objection.
A. I don't remember oncologists specifically.
Q. I merely use it as an example.
A. Uh-huh. Yes, although I don't believe that oncologists were in that category.
Q. I'm happy to rephrase.
A. Okay.

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Q. Let's do it so the record is clear. I'm trying to understand how the methodology worked. So, if Specialty X, if their income in reimbursements was going to fall by more than a certain predetermined percentage, that would then qualify as an unacceptable impact, and a conversion factor would be applied to increase their reimbursement.
MR. COCO: Objection.
A. Yes, but the predetermined percentage would not necessarily be the same for every specialty.
Q. Vary from specialty to specialty?
A. Yes.
Q. Okay. Do you know what the basis was for varying the threshold impact percentage from specialty to specialty?
A. No.
Q. Do you know for which specialties a higher impact was acceptable than for others?
A. I don't remember.
Q. Now, we've talked about reimbursement for

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services. How was Harvard Pilgrim reimbursing providers for drugs that they administered in office?
A. I don't -- at some point along the way, Harvard Pilgrim contracted with a specialty drug organization, and I don't know the details of it. It was not my area of responsibility.
Q. Did you have an understanding as to whether or not the specialty provider was responsible for all injectable or infused drugs, or were they responsible for a specific subset of drugs?
A. A specific subset.
Q. Did you gain an understanding at any point as to whether providers were required to use the specialty distributor to acquire physician-administered drugs, or was it optional?
A. It was -- I don't remember how it ended up. I think the -- the original concept was that it would be required, but it became controversial, and I don't remember how it ended up.
Q. Why did it become controversial?

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A. To the -- my extent of understanding was that providers were -- were not that accepting of having to use a particular vendor.
Q. Did you get an understanding as to why providers were resistant?
A. No.
Q. At any point -- well, when you say resistant to using a vendor, were the concerns specific to the specialty vendor in use, or were concerns related to the use of a specialty pharmacy method?
A. I can't say that I had firsthand knowledge of what it was. I remember that, you know, that there was an objection to just the administrative burden that it placed on the provider. That was one -- one thing that I do remember.
Q. Any concerns other than administrative burden that you recall?
A. Some -- there was some concern about the shelflife of some drugs.
Q. Anything else?
A. Nothing else that I can remember. I'm

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sure there were other things, but I was not a party to that discussion.
Q. Were any concerns expressed that you're aware of regarding a reimbursement, a margin, or any issues of that kind?
A. In the -- in the context of the specialty drug vendor, not that I know.
Q. Now, other than the specialty distribution channel, did you have an understanding as to any other methodologies that Harvard Pilgrim used in relation to reimbursing for drugs administered in office?
A. I believe that there -- there was J-codes that were used as a method of reimbursing on the claim, but I have very limited knowledge as to how that all worked.
Q. Do you know how the reimbursement in relation to any particular J-Code was determined?
A. No, not at that point.
Q. Okay. Do you have a familiarity in general with what J-codes are, what HCPCS codes are?

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MR. COCO: Objection.
A. Limited knowledge. It's just a -- you know, a code that's put on a bill to describe what the drug was or the service that was administered.
Q. Do you understand that a J-Code can apply to a drug or to a service?
MR. COCO: Objection.
A. I don't know that to be true. I always thought they applied to drugs.
Q. Okay. Now, in relation to drugs, do you know whether or not every drug has its own individual J-Code?
MR. COCO: Objection.
A. I don't know.
Q. Now, after your time as manager of the northern region, you became director of contracting.
A. Yes.
Q. You mentioned earlier that your responsibilities were hospitals and large physician risk units.
A. Correct.

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Q. What did you mean by -- by "large physician risk units"?
A. That would be physician groups or a combination of a physician group with a hospital that would have a -- an overlying agreement with the health plan around sharing risk in one of the models that I described, either withhold and a budgeted cap, or global capitation.
Q. Did the various risk-sharing arrangements that Harvard Pilgrim had with physician practices during the time you were there -- '97 to '03 -- include or exclude drugs administered in office?
A. I don't remember that that -- it excluded drugs.
Q. So far as -- so, as far as you knew, the capitated payments that were provided encompassed all medical benefits, services, and drugs.
MR. COCO: Objection.
A. For the -- for the global capitation, yes.
Q. Okay. And in the budgeted capitation model, all medical benefits -- the services and the drugs -- would be part of the analysis used to

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determine the numbers at the end of the day -- at the end of the year.
MR. COCO: Objection.
A. There may have been some that had exclusions for retail drugs or for mental health services, but that's the only exclusions that I can remember.
Q. Physician-administered drugs would have been included.
A. I believe so.
Q. Now, you testified that when you were manager of the northern region, the majority of Harvard Pilgrim's contracts were these risk arrangements.
A. Yes.
Q. Okay. Did that remain true when you were director of contracting?
A. Yes.
Q. So, throughout your time at Harvard Pilgrim, from '97 to '03, in relation to physician providers, the majority of the contracts that you were responsible for negotiating and implementing

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were risk sharing, as opposed to fee for service.
A. I didn't do any fee-for-service contracting. My responsibility was the risk-sharing contracting.
Q. Okay. So, let me rephrase it then. For the period '97 to '03 when you were at Harvard Pilgrim Health Care, you were responsible for risk-sharing contracts, but you understood that those risk-sharing contracts constituted the majority of Harvard Pilgrim's total physician contracts.
A. Yes.
MR. COCO: Objection.
Q. And those risk-sharing contracts included physician-administered drugs.
MR. COCO: Objection.
A. As far as I can remember, yes.
Q. Now, in 2003, you then made a transition to Blue Cross Blue Shield of Massachusetts, right?
A. Yes.
Q. What were the reasons why you moved from Harvard Pilgrim to BCBS of Massachusetts?

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A. I live in Westborough, and they transferred my unit to Quincy. And so, ultimately, the commute became untenable for me, and I had been recruited by Blue Cross and accepted the position.
Q. Okay. And you came to Blue Cross as senior director of provider contracts.
A. Correct.
Q. Now, who is the provider in provider contracts?
A. Hospitals and risk and incentive contracts with physicians' groups. And when I say "hospitals," I mean acute care hospitals.
Q. Now, you said risk incentive contracts.
A. Risk and incentive contracts.
Q. That was my question. Now, are some -- when you say, "incentive contracts," do both -- does that include both fee-for-service contracts and risk-sharing contracts?
A. When I say, "incentive contracts," I mean it's a -- it's an overlay on a fee-for-service -- individual fee-for-service contractsthat provides incentives to a group of physicians -- upside.

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Q. Now, for the period you've been at BCBS, the last three-odd years, what proportion of physician contracts generally have been plain fee for service without incentives?
A. This is a guess, and I'm thinking 50 percent, and our goal is to increase the -- those -- those with incentives.
Q. Okay. So, the fee-for-service contracts, roughly half are without incentive structures, and the other half are with incentive structures?
A. If you're talking about when I began with Blue Cross, I -- I would guess that that would be the breakdown. And then --
Q. And has that changed over the last three odd years?
A. Yes. Yes.
Q. Okay. What's the rough percentage now between the two?
A. I would say about 80 percent with incentives or some sort of shared risk or incentive.
Q. Well, do the risk contracts ever have an

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incentive component?
MR. COCO: Objection.
A. Do the risk contracts have an incentive --
Q. Let me withdraw that. I see your concern. The -- the particular incentive programs that are applied to fee-for-service contracts, are those same incentive programs ever applied to risk model contracts?
A. There may be a -- an incentive component that's applied to the individual physicians within a risk contract. So, we have a PCP incentive that's offered to PCPs, and they also make -- the PCPs may also be part of a risk contract.
Q. Okay. Let's try and look at it a slightly different way then. When you started in 2003, what proportion -- leaving the incentive component aside for a moment -- what proportion of contracts with physicians were fee for service versus risk model contracts?
MR. COCO: Objection.
A. I really couldn't make a guess.
Q. Okay. Were -- do you have an

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understanding as to whether the majority of contracts were fee for service or -- or risk?
MR. COCO: Objection.
A. I believe fee for service was a larger component than I had been used to at Harvard Pilgrim, I'd say.
Q. Was the proportion of risk contracts still substantial, or was it really nominal?
MR. COCO: Objection.
A. I wouldn't call it substantial.
Q. Has that relative division between fee for service and risk changed over the last three years?
A. Not the relative difference between fee for service and -- and risk, no.
Q. Okay. So, this was a substantial difference from what you had seen at Harvard Pilgrim in terms of the proportion of risk contracts to fee-for-service contracts, right?
A. Yes.
Q. Now, let's get to the incentive part of it. On the fee-for-service contracts, I understand in 2003 about half of them had incentives, and now

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that's up to about 80 percent, right, roughly?
A. (Witness nods.) Incentives or risk.
Q. Okay.
A. So --
Q. Let's -- let's talk about that now. When you -- when you refer to incentive programs, are you referring to, for example, the PCPIP program?
A. That's one -- one incentive program, yes.
Q. Okay. And for the record, what does that stand for?
A. Primary Care Incentive -- Primary Care Physician Incentive Program.
Q. What other incentive programs are you familiar with?
A. Today?
Q. Yeah.
A. There's a tertiary physician incentive model; there's a group in -- group physician -- Group Performance Incentive Program, and that's for groups that include PCPs and specialists.
Q. Is that --
A. And there's a hospital incentive program.

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Q. Okay. Is the Group Performance Incentive Program referred to by the acronym GPIP?
A. Yes.
Q. Okay. So, you described four incentive programs. Is that the sum total of incentive programs currently in place?
A. Yes, and there's variations around the GPIP program.
Q. Okay. Have there been other programs in place during your time at BCBS of Massachusetts which are not in place at the moment?
A. No.
Q. Was the -- did the PCPIP program previously go by a different name?
A. Not to my knowledge.
MR. MANGI: We can take a quick break now, if you like.
VIDEO OPERATOR: The time is 10:51. We're off the record.
(Recess was taken.)
VIDEO OPERATOR: The time is 11:09 a.m. We're on the record.

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Q. Now, earlier in the day we were talking about your time at Harvard Pilgrim, and we discussed how you had been involved in Harvard Pilgrim's transition from using homegrown fee schedules to an RBRVS-based methodology.
A. Yes.
Q. Do you recall that testimony?
A. Yes.
Q. Okay. I'd like to talk about that a little bit more. Can you describe for me in terms of process how that transition was organized and took place?
A. Senior leadership requested that the organization look at an industry standard fee schedule.
Q. When did that take place?
A. I -- I don't remember --
Q. Okay.
A. -- the dates.
Q. Sometime in the late '90s?
A. Yes.
Q. Okay.

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A. And a committee was formed, cross-functional team with analysts and systems people and payment policy people, and -- and I was a member of the team. And I wasn't necessarily a constant member of the team, but attended the team meetings from time to time. And a lot of analysis was done on payments -- current payments and -- and what it would look like if it transitioned to the industry standard fee schedule.
Q. Did the team have any particular name?
A. Not that I remember.
Q. What happened after the analysis was done?
A. There was a lot of paper generated, and different members of the team looked at the results from the perspective of their own departments, and over time, there was a -- a fee schedule that sort of grew out of that process.
Q. Who made the final decision as to whether or not to proceed with the transition?
A. I don't know ultimately, but my boss indicated to me that the -- that the decision had been made to transition. So, I don't know if it

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came from higher down to her or where -- where it came from.
Q. Did the team with which you were involved in studying the transition provide a recommendation as to whether or not the transition should take place at any point?
A. No.
Q. Okay. Well, was the team's mandate -- original mandate from senior management -- to assess the viability of transitioning, or was it to transition?
A. I don't know what the -- what the original mandate was.
Q. Okay.
A. It was to look at an industry standard fee schedule and to -- and to analyze the impact of moving from what was in place to the industry standard.
Q. Approximately how long was it from the time when senior leadership gave the instruction to start looking at this issue up until the time when your boss told you that the transition was going to

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take place?
A. I don't know.
Q. Okay. Are we talking a matter of days --
A. No.
Q. -- weeks, months, years?
A. I -- I don't know for sure, but it's not days, weeks, or months. It's more.
Q. Okay. So, it would be a -- a few years?
A. It would be at least a year.
Q. Okay. Now, after the decision was made to go ahead with the actual transition, in other words, after all the discussion was complete, the analysis was done, and the decision was made, okay, we're going to make the transition, how long was it, approximately, from that point until the systems were updated and the new methodology was ready for use?
MR. COCO: Objection.
A. That's just outside of my area of expertise, that -- that time frame.
Q. Do you have an understanding as to how long it was before you were able to negotiate and

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start signing contracts utilizing the new fee schedule?
A. I don't believe there were contracts negotiated and signed using the new fee schedule. There was a fee schedule update that was produced to the network.
Q. Well, at that point when Harvard Pilgrim signed a fee-for-service contract, was a fee schedule appended to the contract?
MR. COCO: Objection.
A. I didn't handle individual physician fee-for-service contracts, so the paper that a provider would sign, I never saw.
Q. But you do know that the transition was accomplished, right?
A. Yes.
Q. Do you know whether that transition -- so, after the analysis was done and just the implementation phase, do you know whether that was a matter of days, weeks, or months?
A. Let me back up just for a second on the transition, because I'm -- I'm remembering that

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there were some providers that did not transition. So, it didn't -- it did not happen across the board.
Q. Well, let's talk about that first. Why -- why did some providers transition and not others?
A. I -- I believe it was a negotiation at -- at a large physician group, multi-specialty group level.
Q. So, physicians -- withdraw that. Were physicians aware that Harvard Pilgrim was implementing this transition?
A. Yes.
MR. COCO: Objection.
Q. How did they become aware of the fact that Harvard Pilgrim was implementing the transition?
A. I can only speak for the physicians that I made aware, and that would be through a conversation or a negotiation at a higher level.
Q. Were these ad hoc, sporadic conversations, or did you set out to inform all of the clients for whom you were responsible of the transition?
A. There was a generalized communication to

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the network.
Q. Was there a standard letter that was sent out?
A. I -- I don't know what the mechanism was. There might have been multiple mechanisms --
Q. Okay.
A. -- for communication.
Q. But the goal was to make all providers aware of the fact that the transition was taking place?
A. Yes.
Q. Okay. Do you recall what the time frame was between when your boss told you that the transition -- that the decision's been made to proceed with the transition and when you started communicating to providers that the transition was now in process?
MR. COCO: Objection.
A. Can't remember the time frame.
Q. Do you know if it was a matter of weeks or months?
MR. COCO: Objection.

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A. I don't know.
Q. Okay. Was the transition complete prior to 2000?
A. I can't say for sure. It was right around in that time frame.
Q. The physicians that did not -- withdraw that. You described a process of negotiation related to the transition. Did that process take place at the same time for all plans, or did it take place whenever contracts came up for renewal?
A. Did it take place for all plans?
MR. COCO: Objection.
A. If you could just repeat the question.
Q. Sure. Did the -- you mentioned earlier that some provider -- that there was a process of negotiation between Harvard Pilgrim and providers related to the transition. My question is, were -- or did those negotiations all take place at the same time, or were they staggered in order of whenever a provider's contract came up for renewal, the discussion would take place at that time?
MR. COCO: Objection.

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A. When you say, "provider," my responsibility was with large provider groups, not individual providers --
Q. Okay.
A. -- and so, to that extent, for a large provider group, it would be upon renewal of the contract.
Q. Were these generally contracts that came up for renewal every year or on a different time frame?
A. It depended on the particular group.
Q. What was the minimum duration of any of these contracts?
A. A year.
Q. The maximum duration?
A. Unlimited.
Q. Well, when did you raise the issue of the transition for -- with entities that had unlimited-time-duration contracts?
A. There may have been a -- sometimes when there's unlimited -- and what I mean by that is it automatically rolls over each year, unless one of

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the parties asks to sit down and negotiate; and so, that would have been what Harvard Pilgrim did in those cases.
Q. Eventually, did all physician practices transition over to the new RBRVS-based methodology?
A. When I left Harvard Pilgrim, there were still some that had not.
Q. Now, after the decision was made to proceed with the transition, what groups were responsible for implementing that transition?
MR. COCO: Objection.
A. You mean departments of the organization?
Q. Yeah.
A. Well, there would need to be a claim -- the claims system needed to be updated to properly pay claims, and that would have been the implementation.
Q. Any other departments?
MR. COCO: Objection.
A. To implement -- and when you say, "implement," I'm thinking you mean to put in place the appropriate system to pay correctly.

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Q. I'm -- I'm referring to any logistical mechanical task that had to be performed to make the transition a reality after the decision had been made to go ahead and transition.
MR. COCO: Objection.
A. Tasks that would include something beyond the actual paying of the claim?
Q. Well, let's -- let's -- let's list some of the areas. The claims system needed to be updated. That's one --
A. Uh-huh.
Q. -- area you mentioned. And it needed to be updated in the sense of all payment methods and amounts had to be changed, right?
A. Correct.
Q. So, it wasn't so much an update as it was a change in the payment methodologies and amounts in -- throughout the claim system.
A. It would have been the implementation of a new fee schedule.
Q. Okay.
A. But it wouldn't -- there would be multiple

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fee schedules already in the system.
Q. Was there another department responsible for fee schedules, or was that handled by the same department that handled the claims system?
MR. COCO: Objection.
A. There was a reimbursement department that was responsible for giving the claims department the appropriate information.
Q. Any other departments that became involved in that process that you're aware of?
A. In the process of implementing -- not that I'm aware of.
Q. Now, did you -- oh, were there any particular problems or challenges that emerged in the course of that transition, as far as you're aware?
MR. COCO: Objection.
A. What -- what do you mean by "challenges"?
Q. Well, let me -- let me rephrase it then. Were -- did the transition -- once it -- withdraw that. Once the decision had been made to proceed with the transition, did things proceed smoothly,

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or were there any major bumps and problems along the way?
MR. COCO: Objection.
A. I can't recall any specific problems that I would have dealt with.
Q. Did you hear of any problems that you weren't involved in dealing with?
MR. COCO: Objection.
A. I wouldn't call it a problem -- any problems, except that there were discussions with some of the large groups that wanted to negotiate.
Q. So, leaving aside the willingness of providers to make the transition, you're not aware of any difficulties that Harvard Pilgrim encountered, logistically, in making the transition from one methodology to another?
MR. COCO: Objection.
A. I'm not aware of it, no.
Q. Now, we talked a bit later this morning about the different incentive programs that are in use at BCBS of Massachusetts.
A. Uh-huh.

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Q. The first one you mentioned is the PCPIP.
A. Yes.
Q. Can you help me understand what that program is.
A. I don't manage the program, but I'm certainly aware of what it is, and it's a -- it's a program that provides additional revenue to primary care physicians based on their performance in certain quality goals and technology goals.
Q. What are the goals that ground the granting of a performance incentive?
A. I don't remember specifically all of them, but they fall in the categories of HEDIS goals around, I think -- I think this year we have diabetes measures, and in the past we had, you know, mammography and Pap smears.
Q. Would it be fair to say that the incentive programs relate principally to success in implementing preventative care regimes?
A. That would be a part of it, yes.
Q. Okay. What else is involved other than preventative care?

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A. Utilizing electronic technologies like eRx.
Q. What is eRx?
A. So, that's electronic prescription writing, handheld devices.
Q. Anything else?
A. I think that's -- you know, quality and safety are the general guiding principles for PCPIP.
Q. How are quality and safety assessed?
A. How are they assessed?
Q. How are they assessed?
A. Well, we use industry standard HEDIS reports for quality; and so, the eRx would fall into a safety category, and that would be assessed by the usage of how many prescriptions a provider writes using the electronic prescription writing.
Q. The second program you referred to is the tertiary physician model.
A. Yes.
Q. What is the tertiary physician model?
A. It's a new model that was implemented in

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January of '06 for certain groups of physicians that are affiliated with tertiary hospitals, and it's an incentive model that incents -- provides additional revenue based on performance in quality, efficiency, and technology goals.
Q. What are tertiary hospitals?
A. The tertiary -- the tertiary -- what's the definition of a tertiary hospital --
Q. Yeah.
A. -- or specifically -- who are they?
Q. No, what is a tertiary hospital?
A. The definition? It's a hospital that provides, you know, a higher level of services, like transplants and -- there's a criteria, and I can't say all of the pieces of the criteria, but it differentiates a hospital from a community-level hospital that provides a different set of services.
Q. Are the incentives under the tertiary physician model going to the hospital or to the physicians practicing in the hospital?
A. To the physicians affiliated with the hospital.

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Q. Is the contract signed between BCBS of Massachusetts and the physician or the hospital?
A. Physician group.
Q. So, these are contracts with physician practices where the physicians have an affiliation with the hospital.
A. It's a contract with an organized group of physicians that have a centralized infrastructure and -- and a centralized authority to negotiate on their behalf.
Q. Okay. Now, does this incentive program have any connection with preventative care goals, like the PCPIP?
A. There is some of that.
Q. The eTechnology component, I assume, is the same as the PCPIP, to promote the use of technology?
A. It may be that. It may be an electronic medical record, but there would be a goal that would be connected to some technology.
Q. Are there any goals that fund incentive payments under the tertiary physician model that

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we've not previously discussed in connection with the PCPIP?
A. There would be some efficiency goals that may look at appropriate utilization for radiology.
Q. Are you referring to the use of radiotherapy in general or drugs associated with radiotherapy?
MR. COCO: Objection.
A. It would be radiology services like CT scans, MRIs.
Q. Oh, I see. The third model you mentioned is the Group Performance Incentive Program. What does that program involve?
A. That is a beat-the-trend model, and basically the underlying structure is a physician group that beats a network trend; that does better than the network trend, and there would be some opportunity for incentives based on their performance.
Q. What sort of trends are being measured?
A. Medical cost trends.
Q. Does medical cost include the cost of

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services as well as drugs?
A. It includes the cost of all medical expenses. And that model has evolved over time and now only includes some subsets of the medical expenses.
Q. Is it a second cousin to a withhold program?
MR. COCO: Objection.
A. I don't know what you mean by "second cousin."
Q. Was it --
A. I think of my second cousins. I don't know.
Q. It wasn't a legalistic question. Let me -- let me ask it again. Does the Group Performance Incentive Program have a similar structure to a withhold program in the sense that, if total payments are contained within a certain range, that can be the basis for the granting of an additional financial sum?
MR. COCO: Objection.
A. There is no withhold in this program.

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Q. Okay. So, it's merely -- it's a -- it's an additional sum that becomes available as a bonus incentive payment if cost containment goals were met?
A. Cost containment and other goals, including safety and technology.
Q. Okay. Now, you said some elements are included and some are now excluded from the measurement of medical cost. What was the change that you were referring to there?
A. I'm sorry. They are all still included, but now they are seg -- separated into categories.
Q. So, they're measured separately?
A. Yes.
Q. Okay. What are the categories that are measured now?
A. Lab -- let's see if I can remember them -- lab, radiology, retail pharmacy, and all other.
Q. In the retail pharmacy category, what is being measured there?
A. Trend.
Q. Well, is -- is -- does the retail pharmacy

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measure the cost to the plan of scripts that the doctors write for drugs that patients then fill at retail pharmacies?
A. Yes.
Q. Now, in those situations, the doctor will write a prescription, the patient will fill it, say, at a CVS or an Eckerd's, and BCBS will then make reimbursement to that pharmacy, correct --
A. Uh-huh. Yes.
Q. -- via Express Scripts, which is the PBM?
A. Yes.
Q. In those situations reimbursement does not flow through the doctor.
A. Correct.
Q. But nonetheless, this program seeks to measure the cost to BCBS of Massachusetts of reimbursing in relation to prescriptions that the doctor writes.
A. Correct.
Q. And that then becomes part of the analysis of whether or not the doctor can achieve an incentive under the GPIP.

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A. Yes.
Q. Where in the structure that we described is the cost measured of drugs administered in office?
A. It would have to be in the "all other" category.
Q. Do you have any idea how much BCBS of Massachusetts pays each year in reimbursement to physicians for drugs administered in office?
A. No.
Q. How long has the GPIP program been in place?
A. Four years is my -- it was in place before I arrived. So, I've been there three years, and I think it was in place a year before I got there.
Q. Now, the GPIP program applies to both primary care doctors and specialists?
A. Yes.
Q. Does it apply to specialists in a variety of different fields?
A. Yes.
Q. Are any types of specialists excluded from

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the GPIP?
A. No, not -- well, it really would be a function of the group that -- that the contract is with. So, if they have only certain specialties, then -- then the others would not be included.
Q. To put my question another way, am I correct in understanding BCBS of Massachusetts has not made any sort of a policy decision to exclude any particular specialties from the scope of the GPIP program -- GPIP --
A. When you say, "specialties," I'm not sure if you're including some of the ancillary categories, like, you know, nurse practitioners and --
Q. I'm not. I'm referring to specialties in terms of areas in which physicians specialize -- rheumatologists, oncologists, hematologists, nephrologists.
A. None of them have been explicitly excluded.
Q. And the PCPIP program, how long has that been in place?

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A. I don't know. It's been there for many years prior to my arrival. I don't know the number of years.
Q. Now, the fourth incentive program we talked about is the hospital incentive program.
A. Yes.
Q. What does that program involve?
A. That program is -- has been a program that measures -- it's evolved over time, and it started measuring process -- some of the JHACO core measures. And then it's evolved to measure outcomes through -- I'm going to use acronyms that I probably won't be able to tell you what they mean -- AHRQ, A-H-R-Q, it's a national reporting of outcomes; and -- and then the next generation will include some -- some new processes and patient experience -- patient satisfaction and technology.
Q. Now, the first part of that you referred to is measuring J-codes?
A. JHACO. It's a-- it's an acronym. JHACO, J-H-A-C-O, I think.
Q. What is -- what is that?